YOUTH SERVICES OFFICE OF JUVENILE JUSTICE PRE- EMPLOYMENT HEALTH HISTORY QUESTIONNAIRE

IT YES, please answer the following: Physician TICP treating you: Diagnosis: 2. Circle each item that you have had a problem with in the past (meaning since birth to present): A. MUSCLES, BONES, AND JOINTS (Pain, sprain, fracture, dislocation, surgery): Neck Upper back Mid back Lower back Hip Knee Ankle Foot Shoulder Elbow Wrist Hand Fingers Arthritis Gout Provider comments: B. SKIN: Itching Rash Hives Fezema Provider comments: C. CHEST AND LUNGS: Asthma Shortness of Breath Provider comments: D. NEUROLOGICAL: Sezures/Epilepsy Fainting Blackouts Muscle weakness Paralysis Numbness Tingling in hands, feet of file Provider comments: E. HEART: Heart problems? High Blood Pressure Provider comments: F. EXDOCRINE: Diabettes Thyroid problems Any other endocrine problems? Provider comments: G. GASTROINTESINAL (GI): Any history of stomach' other GI problems? Hepatitis Hernia Provider comments: H. MESTAL HEALTH: Any uncontrolled anxiety/depression/other problems? Provider comments: 1. INFECTIONS: Herpes infection of the finger? Cold sores Tuberculosis Hepatitis A B C (circle all) Provider comments: 3. YES NO Do you have problems with lates gloves/other rubber products? If YES, please deplair, If YES, please deplair, S. YES NO Have you had the Medales? 7. YES NO Have you had the Medales? 8. YES NO Have you had the Medales? 9. List Allergies you have to food, drugs, pollens, chemicals, lateve, etc:	١.	YES	NO A	Are you currently under the	care of a physician/ healt	h care provider?						
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	-											
	11	VEC	NO	A Have you over been	hospitalizad?							
Evaloine	11.	YES	NO	Explain:	nospitanzea?							

Page | 1 of 2

	YES	NO	B. Have you ever had surgery?				
	_		List year and type:				
YES NO C. Do you have persistent (circle) upper back pain, mid-back pain, low back pain, neck pain, or arm pain? If yes:							
			Do you now have pain: Rarely Occasionally Frequently				
			What is the longest period of time this bothered you?				
			When was the last time you sought medical evaluation?				
			•Yes No Do you have any numbness/tingling/weakness in your arms or legs? If yes, Where:				
			Yes No Have you had surgery or seen a surgeon for this problem?				
			IMMUNIZATIONS:				
Please respo	nd Yes, No,	or NS (Not S	Sure)				
1 YI 2 YI		NO NO	NS Tetanus Year: NS Hepatitis B Year: If yes, titer; Year: Results:				
3. YI		NO	NS Hepatitis A Year:	_			
4. YI 5. YI		NO NO	NS MMR Year: If yes, Rubella titer; Results: Year: Year:				
J 11			PERSONAL HEALTH HABITS HISTORY:				
1 37	50	NO H					
	ES ES	i.	re you a current smoker? If No, when did you quit?				
		NO AI	e you a current smoker: If No, when did you quit:				
2 Y	ES	NO Do	o you drink alcohol? How much do you drink each week?				
3. Y	ES	NO Ha	ave you ever been treated for chemical (illegal or legal drugs or alcohol) dependency?				
			Explain:				
			PAST WORK HISTORY:				
1. Give	vour immedi	ate nast ioh t	title (Custodian, Administrative Assistant, Physician, etc)				
	,	this position					
2.	YES	NO	Have you ever been injured on the job in any way? If yes, explain:				
							
3.	YES	NO	Have you ever received Workers Compensation benefits?				
			If yes, please answer the following:				
			Name of employer at the time of injury?				
			Type of injury:				
			Date of injury:				
			Job title at time of injury:				
			How long were you off work:				
4.	YES	NO	Have you ever had to transfer from one job to another, or changed work duties because of health problems?				
-	MEG	NO	Explain:				
5.	YES	NO	Have you ever been refused any job for health problems?				
6.	YES	NO	Explain: Has a doctor ever placed restrictions on the kind of work or activities you should do?				
J			Explain:				
7.	YES	NO	Have you ever received an impairment rating or a disability rating?				
	_		Explain:				
Applicant's	Signature:		Date:				
Provider Si	gnature:		Date:				

Page | 2 of 2 April 2011